



NC DMA Carolina ACCESS Override Request Form



Recipient Information

DMA-0010

Recipient ID #: _____
Last Name: _____ First Name: _____
Date of Birth: _____ Gender: _____ Date(s) of Service: _____

Requesting Provider's Information

Requesting Provider's NPI #: _____
Requesting Provider's Name of Practice: _____
Site Address: _____
City: _____ State: _____ 9 Digit Zip Code: _____

CCNC /CA PCP Information

Verified name of the PCP on record on the Date(s) of Service per the EVS or AVR:

Person contacted at PCP's Office: _____ Date contacted: _____

Reason the PCP stated he/she would not authorize treatment: _____

Reason recipient did not go to the PCP on record: _____

Reason services were provided prior to receiving PCP authorization or requesting an Override: _____

Diagnosis or presenting symptoms: _____

Override Information

I am requesting an override due to:

☐ Enrollee linked incorrectly to PCP. Please explain: _____

Who is the correct PCP? _____

☐ Child has been placed in foster care in another area: _____

☐ Recipient has moved to another county: _____

☐ An inpatient admission from the Emergency Dept.

☐ Recipient's condition is catastrophic. Please explain: _____

☐ Unable to contact PCP. Please explain: _____

☐ Recipient is in a course of treatment. Please explain: _____

☐ Other. Please explain: _____

*Complete this form to request a Carolina ACCESS override when you have received a denial for EOB 270 or 286 or the Primary Care Provider (PCP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted within six months of the date(s) of service. Overrides will not be considered unless the PCP has been **contacted and refused** to authorized treatment. Instructions for completing this form can be found at <http://www.NCTracks.com/PAformhelp>*

Requestor's Name _____ Phone Number: _____ Ext _____

Requestor's Signature: _____ Date: _____

Fax this form to CSC at: (855) 710-1964